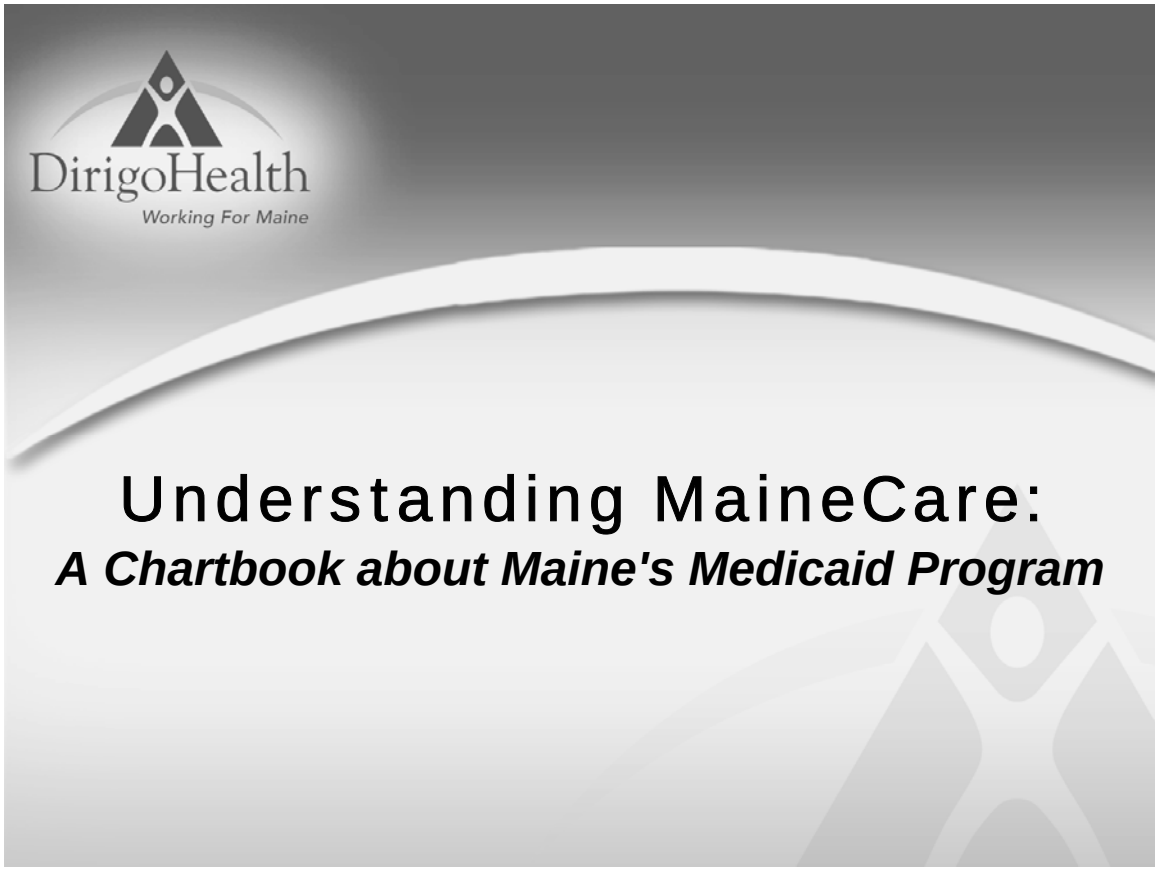

Understanding MaineCare:

A Chartbook about Maine's Medicaid Program

Prepared for the Governor's Office of Health Policy and Finance

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UNDERSTANDING MAINECARE: A CHARTBOOK ABOUT MAINE'S MEDICAID PROGRAM

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INTRODUCTION

This Chartbook provides information about Maine's Medicaid program – known as MaineCare – which provides health and long-term care coverage to low-income, disabled, and elderly residents. MaineCare is a key building block for Dirigo Health Reform, providing access to care for hundreds of thousands of Maine citizens each year.

Background

Though a large share of the state's population obtains health insurance coverage through their or their family's employer, such coverage is not available or accessible to many residents. Some people work in jobs that do not offer coverage, some cannot afford payments for coverage, and some are out of the workforce. In addition, private insurance typically does not provide coverage for costly long-term care needed by some elderly and disabled residents. Research has shown that without insurance coverage, people forgo needed care, leading to bigger and more costly health problems down the line and sometimes even death. Lack of insurance also has significant financial consequences, such as personal bankruptcy, inefficient use of resources, bad debt, and cost-shifting to other payers.

MaineCare aims to address these issues, assisting low-income, disabled and elderly residents in the state in accessing needed health care and social services, providing protection from catastrophic financial costs of medical care, and facilitating efficient use of quality health services. MaineCare is primarily targeted to the 15 percent of the population (nearly 200,000 people) with incomes below the poverty line, or about $14,000 for a family of three. The program also serves some individuals with slightly higher incomes, generally below twice the poverty line. MaineCare fills in much of the gap in insurance coverage in the state, but a significant percentage of the state's population still has no insurance coverage.

MaineCare operates as a federal-state program in which the state receives matching payments from the federal government and must meet federal guidelines and requirements. Federal rules specify some people and services that the state must cover ("mandatory" groups and services) and also specify those that the state may opt to cover ("optional" groups and services). In addition to financing its share of the program costs, the state makes decisions about MaineCare structure and oversees the day-to-day administration of the program. In doing so, MaineCare works with both enrollees and health care providers, providing the link between these two groups through payment and procedures. MaineCare costs rise as health care inflation grows (nearly three times the rate of regular inflation) and as the program grows, but must operate within a balanced budget. This requires choices by the Legislature among enrollment, services and provider rates. Historically, many providers are paid less under MaineCare than commercial rates.

MaineCare has evolved as the health needs of the population have changed. Over time, the program has incorporated new approaches to delivery of care (e.g., managed care and community-based long-term care) and provided coverage to meet emerging needs (e.g., HIV/AIDS and mental health care). However, the program faces many challenges in fulfilling its mission. In recent years, the state has faced a budget shortfall, making it difficult to maintain coverage levels and requiring prioritization of needs. MaineCare also must work with other state programs to deliver services and is currently undergoing a large effort to coordinate behavioral health services across the state. Last, MaineCare is an important component of the state's health reform efforts to extend insurance coverage and improve the health system for all residents.

Highlights

The charts that follow provide an overview of MaineCare, detailing who the program serves, what the program covers, how it is financed, what spending looks like, how the program is administered, what impact it has, and how it compares to other states' Medicaid programs. Highlights include:

- MaineCare is available to state residents through several "eligibility pathways." Nearly 40% of program enrollees are children; about a third are non-disabled, low-income adults, and about a quarter are elderly and disabled individuals. Enrollment has increased in recent years as a result of initiatives to provide prescription drug coverage and assist adults who do not have children, guaranteeing that MaineCare provides universal access to all Mainers living at or below the federal poverty line; over the course of 2004, 308,453 individuals were, at some point in time, MaineCare members.

- Long-term care and behavioral health care account for a large share of MaineCare spending, together making up over half of program expenditures in 2004. Spending per enrollee varies by group, with children and parents costing the least per enrollee and pregnant women, elderly and disabled costing the most. Elderly and disabled enrollees' greater need and utilization mean these groups account for a disproportionate share of spending: though 26 percent of enrollees, they account for over 60 percent of spending.

- MaineCare provides a mix of preventive, acute, and long-term care services to enrollees. Many services are similar to those found in private plans, while others (such as long-term care and non-emergency transportation) are targeted to the special needs of the population served by the program. Due to enrollees' low-incomes, cost sharing requirements are minimal. MaineCare has special initiatives to improve the delivery of long-term care services and enhance the quality and efficiency of care financed by the program.

- State dollars account for about one-third of program costs, with federal funds making up the rest. MaineCare is the largest source of federal financing to the state, accounting for over 40 percent of federal grants. The program accounts for 20 percent of state general fund expenditures, second to elementary and secondary education (36%).

- As MaineCare has evolved, program spending has also increased, as has national health care and Medicaid spending. In many years, increases in MaineCare costs are on par with national trends; in years when the state has a special initiative or expansion, program costs have increased at a faster pace.

- Over the past eight years, cost drivers have included prescription drugs and related services and behavioral health care. Recent efforts to slow the pace of prescription drug spending have led MaineCare's prescription drug costs to increase at a slower rate than national trends.

- MaineCare is administered by the Bureau of Medical Services within the Department of Human Services. Administrative costs for the program make up a much smaller share of spending than such costs do for other payers in the state.

- MaineCare has helped to make up gaps in insurance coverage in the state and improves access to care for the populations it serves. After a drop in the share of the population with

employer-sponsored coverage, MaineCare slowly expanded to make up the gap in coverage, stemming the impact on the uninsured.

- MaineCare's eligibility levels are similar to the national median for children but are above national averages for parents. Compared to other states, the program reaches a larger share of its target population, covering over half of poor and over 40 percent of low-income residents.

- Maine spends a slightly larger share of its budget on Medicaid than other New England states, but the rate of increase in program spending is on par with national trends and in the middle of New England states. Spending per enrollee is higher than national averages but similar to other New England states. While enrollees in Maine's Medicaid program are more likely to be disabled and elderly than in other New England states, the state spends a smaller share of its expenditures on these populations than other states.

MAINECARE ELIGIBILITY
WHO GETS COVERAGE
&
WHY COVERAGE IS IMPORTANT

WHO'S ELIGIBLE FOR MAINECARE & WHY ELIGIBILITY MATTERS

MaineCare provides universal coverage for all Maine residents living below the poverty level as well as for many other low income persons. Maine residents can be eligible for MaineCare coverage through several eligibility pathways. Some individuals must be covered under federal Medicaid law, but in many cases, the state has opted to cover residents at income levels above federal limits or extend eligibility to additional groups. Pregnant women, infants, and children are eligible for MaineCare if they meet income eligibility criteria outlined above. Some children are eligible for federal State Children's Health Insurance – or SCHIP – coverage, which in Maine is provided through the CubCare program. Non-categorical adults, or adults without dependent children, can be covered through a waiver program approved in August 2002 if their incomes are below the poverty level. Elderly and disabled residents are also eligible for MaineCare; some qualify because of their low incomes, while others have slightly higher incomes but need assistance in order to remain in the workforce (Working Disabled), need help paying for long-term institutional care (Disabled in Need of Institutional Care), or need assistance with Medicare Part B premiums (SLMB and QI).

In addition to the principal pathways described above (and shown in the chart below), there are some special programs within MaineCare that extend eligibility to additional groups. For example, families who lose eligibility as their income increases due to transitioning from cash assistance to work receive temporary coverage. Some other covered groups include children receiving adoption assistance, refugees and asylum seekers, uninsured women who need treatment for breast or cervical cancer and were screened under the program sponsored by the Centers for Disease Control, children who live in the community but would be eligible for MaineCare if they resided in an institution ("Katie Beckett"), and individuals living with HIV/AIDS.

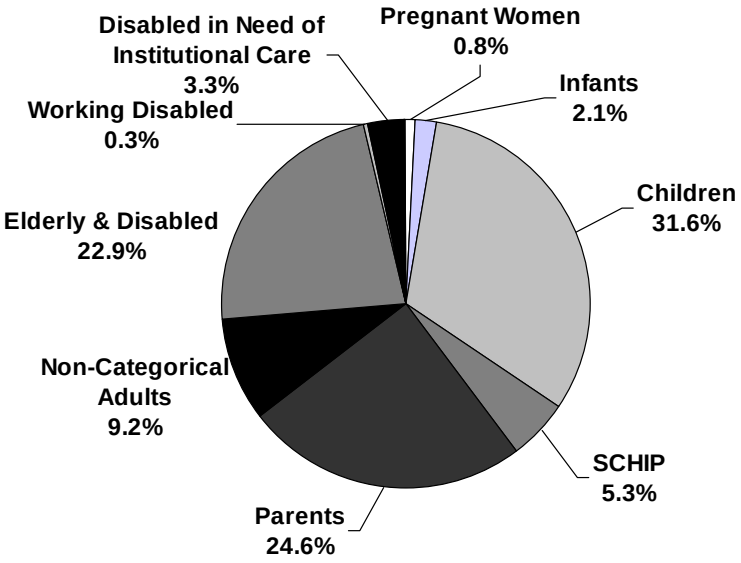
MaineCare Eligibility Rules by Pathway, 2004

Population	***Income Limit***	***Asset Limit****	***Note***
Pregnant women	200% FPL	None	60-day post-partum eligibility
Infants (< 1 year)	200% FPL	None	12-month continuous eligibility
Children (1-19 years)	150% FPL	None	12-month continuous eligibility
Cub Care (SCHIP) children	200% FPL	None	12-month continuous eligibility
Parents	150% FPL	$2,000 per unit	
Non-Categorical Adults	100% FPL	None	
Elderly & disabled	100% FPL	$2,000/$3,000 per individual/couple	
Working disabled	250% FPL	$8,000/$12,000 per individual/couple	
Disabled in need of institutional care	300% SSI standard	$2,000/$3,000 per individual/couple	
Specified Low-income Medicare Beneficiary/Qualifying Individual	100-135% FPL	$4,000/$6,000 per individual/couple	Only covered for Medicare Part B premiums

SOURCE: MaineCare Eligibility Manual. NOTE: 100% FPL (Federal Poverty Level) was $15,670 for a family of three in 2004. Beneficiaries must also be residents of the state of Maine with the intention of making a home in the state. Coverage is available for refugees, asylum seekers, children eligible for federal adoption or foster care assistance, and women screened for breast or cervical cancer under the under the Center for Disease Control and Prevention Program and found to need treatment for one of those conditions. Families who do not meet income criteria due to increased earnings or child support may be eligible for temporary assistance.

* Some assets, such as a home, primary vehicle, and certain types of savings (including IRAs) are not counted.

MaineCare Enrollment by Eligibility Group, SFY04



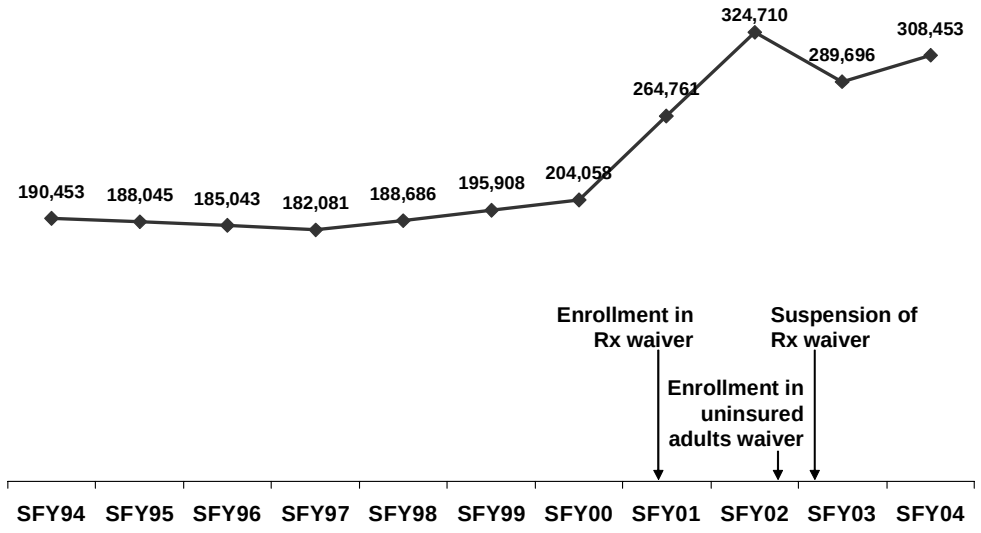
Total = 308,453

SOURCE: Bureau of Medicaid Services administrative data.

MaineCare served more than 300,000 residents over the course of 2004. This figure represents the total number of individuals who were eligible for benefits at any point during the year. The number of people eligible at any single point in time will be smaller, as people cycle on and off the program over the course of a year.

A significant number of enrollees are children: MaineCare children and infants and SCHIP children made up nearly 40 percent of total enrollment in state fiscal year 2004. Non-disabled adults, including pregnant women, parents and childless (also known as “non-categorical”) adults, made up over a third (34.6%) of enrollees. Aged individuals and individuals with disabilities accounted for a little over a quarter (26.5%) of enrollees. This count does not include people solely eligible for drug benefits.

Total MaineCare Enrollment by Year, SFY94-04

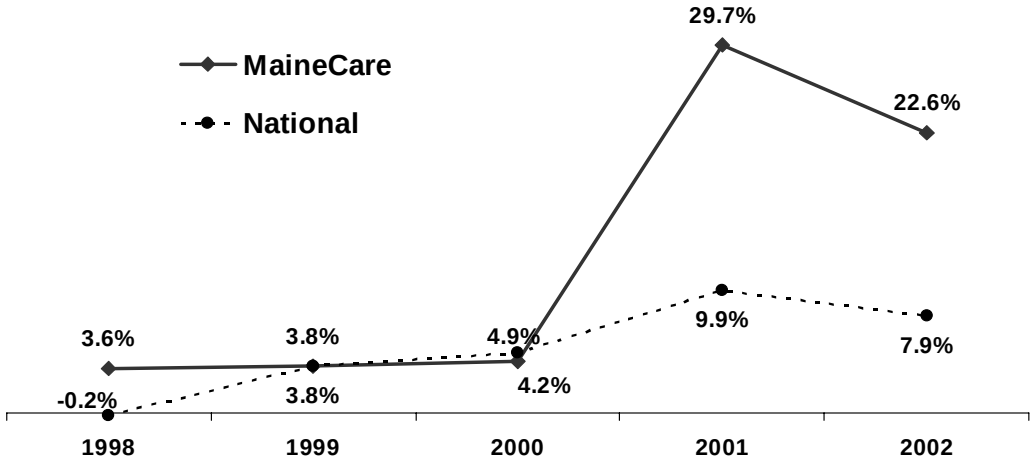


SOURCE: Bureau of Medicaid Services administrative data.

This chart shows the total number of individuals served by MaineCare over the course of time. This total is different (and larger) than the number of individuals who are served by the program at any single point in time.

MaineCare enrollment was fairly steady until 1998, when there was an increase in enrollment following the implementation of the Healthy Maine Prescription waiver in 2001. As this program was suspended, enrollment dropped slightly, but the implementation of the non-categorical adult coverage waiver occurred at the same time, as did Maine's economic downturn, keeping overall enrollment above previous levels.

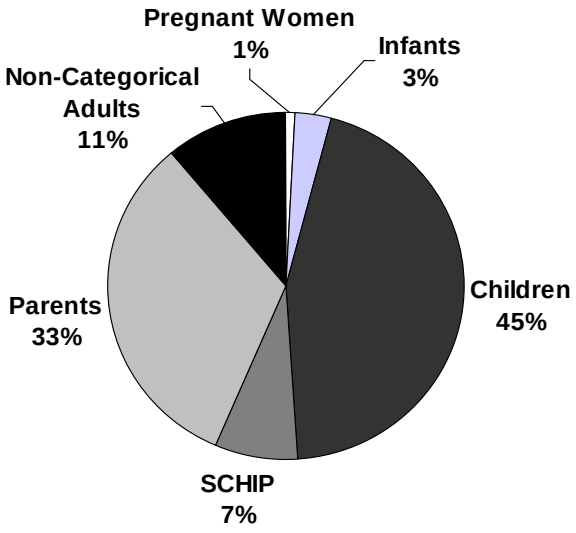
Annual Percent Change in MaineCare and National Medicaid Enrollment by Year, 1998-2002



NOTE: Maine data is for state fiscal year; national data is for calendar year.
SOURCE: Bureau of Medicaid Services administrative data; Kaiser Commission on Medicaid and the Uninsured, Medicaid Enrollment in 50 States, December 2002 Data Update.

Compared to national trends, MaineCare enrollment growth was very similar to overall Medicaid growth in the late 1990s. After 2000, both national trends and MaineCare growth increased more rapidly than in the past. In 2001 and 2002, the implementation of MaineCare program expansions through the prescription drug and childless adult waiver, as well as Maine's economic recession led to enrollment growth above national averages.

Enrollment of Children and Non-disabled Adults by Eligibility Pathway, June 2004



Total = 189,672

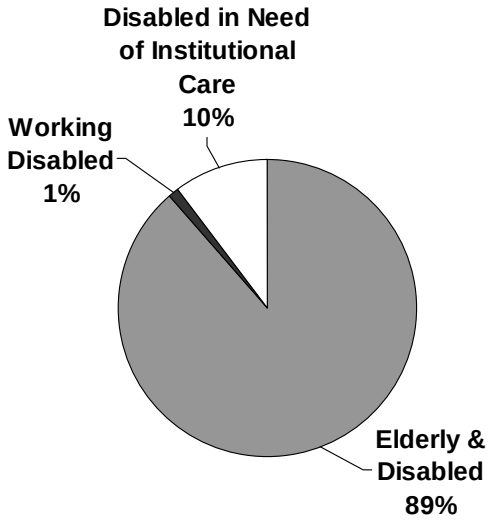
SOURCE: Bureau of Medicaid Services administrative data.

This chart shows the breakdown by eligibility category of MaineCare enrollment during one particular month. This demonstrates the membership at one particular point in time and, therefore, differs from the number of members that are eligible for coverage over the course of an entire year.

Among MaineCare enrollees who are not elderly or disabled, the majority are members of low-income families. Over half (55%) are low-income infants and children who qualify by meeting income criteria for MaineCare or SCHIP, another third are parents of these children. A small number (1%) of enrollees are pregnant women. Just 11 percent are adults who qualify through the waiver program for adults without children.

Most non-disabled, non-elderly enrollees do not have access to coverage through their employer, either because they are unemployed or because their employer does not offer coverage.

Enrollment of Elderly and Individuals with Disabilities by Eligibility Pathway, June 2004



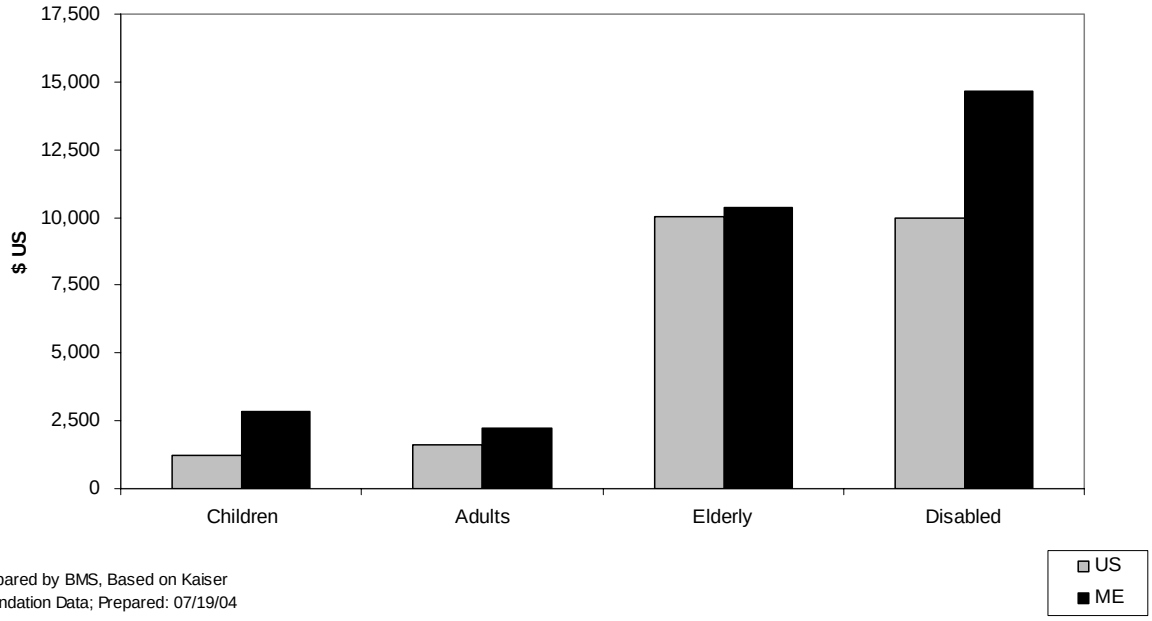
Total = 72,262

SOURCE: Bureau of Medicaid Services administrative data.

The majority of elderly and disabled individuals in MaineCare qualify because they have incomes below the poverty line. Ten percent of elderly and disabled enrollees qualify as disabled in need of institutional care, and just one percent qualify under the working disabled pathway.

Elderly and disabled enrollees rely on MaineCare for services that are not covered through other payers, such as long-term care, are priced out of the private market due to their extensive health needs, or are ineligible for Medicare assistance.

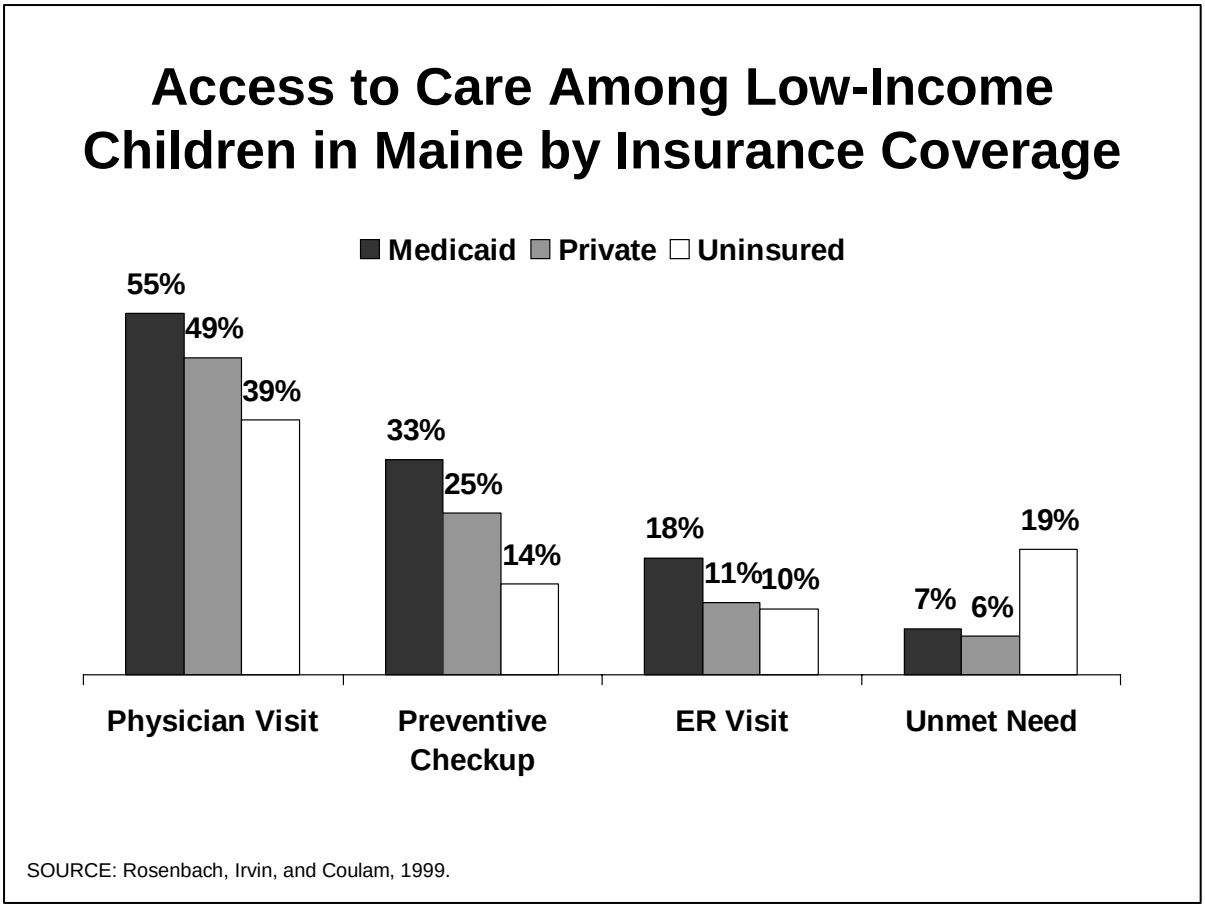
MaineCare Spending by Type of Enrollee
FFY 2000



Prepared by BMS, Based on Kaiser Foundation Data; Prepared: 07/19/04

Although the data used in this chart is dated, it is still informative to compare national spending by major category of eligibility to Maine spending.

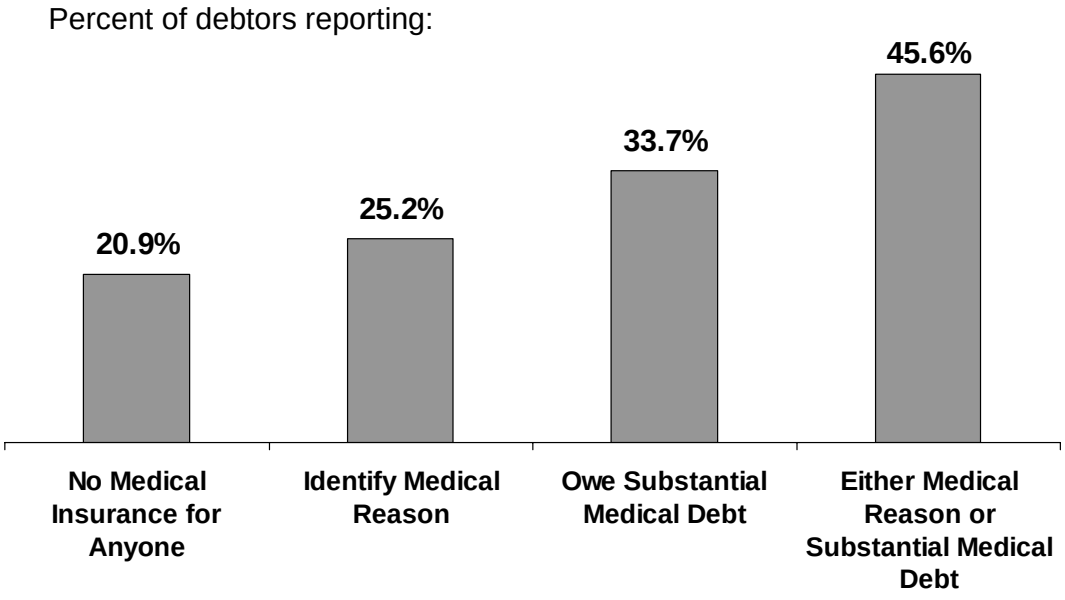
Maine spending (represented by the darker bars) per individual enrollee is essentially equivalent to that spent nationally for adults and for the elderly. Our spending on children is higher than the national average, as is our spending for persons with disabilities enrolled in MaineCare. Differences in spending levels shown in this chart are not attributable to differences in the number of members enrolled in MaineCare compared to Medicaid programs across the country; showing data on average spending per member negates the influence of enrollment levels. Instead, the differences are associated with factors such as the range of services covered under the program as well as to the relatively higher cost of care in Maine as compared to the rest of the country.



SOURCE: Rosenbach, Irvin, and Coulam, 1999.

MaineCare has an impact on enrollees' ability to access care. Compared to children without any coverage, children with coverage through the state's MaineCare program are more likely to receive care, both measured as having a physician visit and receiving preventive check-ups. One potential reason visits to the emergency department are higher for MaineCare children may be insufficient physician availability due to low reimbursement levels. Children covered by MaineCare are also less likely than the uninsured to have an unmet health need. This is one important reason why eligibility matters.

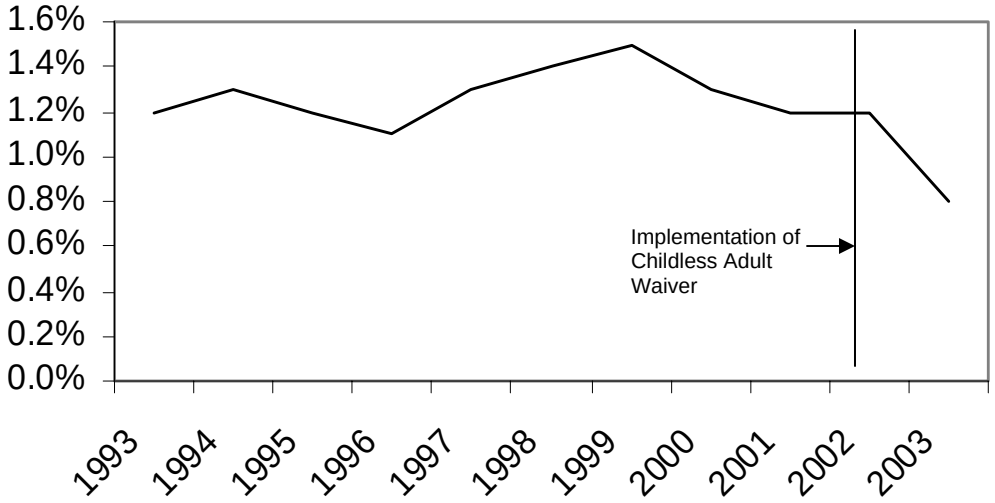
Medical Costs as a Share of Bankruptcy Filings, United States



SOURCE: Warren, Sullivan, and Jacoby, 2000.

Health insurance coverage helps people become financially stable, as it prevents catastrophic out-of-pocket costs. A national study of bankruptcy filings (Maine specific data not available) found that medical costs accounted for nearly half (46%) of all bankruptcy filings. Health insurance that helps families pay for medical costs can prevent these negative financial outcomes from illness. This is another reason why eligibility matters.

Free Care as a Percentage of Hospital Gross Revenues



Data prepared by Nancy Kane, PhD

This chart displays the amount of free care provided by Maine hospitals, shown as a percentage of hospital charges. In Maine, hospitals are required by law to provide free care to any person living at or below the poverty line. However, all these individuals are eligible for MaineCare so many hospitals provide charity care at higher income levels.

In 2002, MaineCare implemented a waiver program, allowing childless adults – who would otherwise be ineligible for benefits – to enroll and receive benefits. The marked decline in the level of free care provided coincides precisely with the introduction of that eligibility expansion.

Importantly, “free care” is not really free. Providers inflate their charges to recover the costs associated with caring for patients who are unable to pay their bills. The inflated charges mean that people who do pay their bills – including people with insurance coverage – are paying more than they otherwise would if the cost of providing care to the medically indigent were to decline. Those who are insured pay for this cost shift in the form of higher premiums. MaineCare helps hold down the cost shifting (and therefore, premiums) by providing some coverage for those who would otherwise be unable to pay their bills.

This is why coverage matters.

WHAT DOES MAINECARE COVER?

COVERED SERVICES

MaineCare provides a range of services to enrollees, some required by federal law and some provided at the state's option. In the case of children, federal law requires MaineCare to cover any federally defined Medicaid service determined to be medically necessary, regardless of whether the service is included in the MaineCare service package. Maine does provide a broader range of services than most other states; a chart comparing services across states is provided in the Appendix of this Chartbook.

Many services are similar to those provided in private health coverage, while others are specifically targeted to the MaineCare population. For example, MaineCare covers long-term care services typically excluded from private coverage, as the program serves a large elderly and disabled population. Similarly, non-emergency transportation is covered to overcome barriers to accessing care that some low-income individuals face.

Some enrollees receive services under MaineCare managed care, in which a provider serves as the enrollee's "primary care case manager." This provider helps provide a medical home to the enrollee and coordinates his/her care.

MaineCare Services, 2004

Preventive Care	Acute Care	Long Term Care	Behavioral Health	Other
•Early intervention (birth through age 5) •Smoking cessation •Asthma and diabetes education •Family planning services and supplies •School-based rehabilitation	•Inpatient & outpatient hospital services •Laboratory and x-ray services •Physician, nurse practitioner services, and other advanced practice nursing services (also those provided in rural health clinics and federally-qualified health centers) •Dental services •Chiropractic services •Ambulance services •Podiatry services •Occupational & physical therapy •Speech, hearing, and language disorder services	•Institutional care (nursing facility and assisted living) •Community-based care (private duty nursing, personal care, hospice, adult day health)	•Institutional care (inpatient psychiatric services, intermediate care facilities for people with mental retardation) •Community-based care (licensed social worker protective services, psychological services, day habilitation, day treatment, home and community based waiver services for people with mental retardation, community support, substance abuse treatment services)	•Pharmacy •Transportation •Medical supplies and durable medical equipment, eyeglasses, and orthotic and prosthetic devices •Medicare Part B premium payments

MaineCare Cost-Sharing Requirements, 2004

Population	*Premiums*	*Co-payment**
Pregnant women	None	None
Infants (< 1 year)	None	None
Children (1-19 years)	None	None
SCHIP children	$5-20 per child, depending on income	None
Parents	None	$.50-3.00 per day for some services, up to $10-30 per month, depending on service
Non-Categorical Adults	None	$.50-3.00 per day for some services, up to $10-30 per month, depending on service
Elderly & disabled	None	$.50-3.00 per day for some services, up to $10-30 per month, depending on service; none if institutionalized
Working disabled	$10-20, depending on income; none if income is less than 150% FPL	$.50-3.00 per day for some services, up to $10-30 per month, depending on service; none if institutionalized
Disabled in need of institutional care	None	$.50-3.00 per day for some services, up to $10-30 per month, depending on service; none if institutionalized

* The following services are free for all beneficiaries: oxygen & equipment, family planning, and emergency services.

Because MaineCare enrollees have low-incomes, federal law limits allowable cost-sharing under the program. Premiums, monthly payments that make a person eligible for payment for services, are charged only for SCHIP children, Katie Beckett enrollees and the working disabled, and are set at low levels. Co-payments, the share of the cost of a service that the enrollee pays at the time the service is used, cannot be used for pregnant women or children. For other groups, co-payments are charged for some services; these payments are set at low levels and are “capped” at $10-30 per month, depending on the service.

Cost sharing rules for other MaineCare groups may differ. For example, at present there are no copayment costs for children covered under the Katie Beckett pathway, while individuals covered under some waiver programs must apply a share of their income to the cost of their care.

Programs to Provide Community-Based Long-term Care Services in MaineCare

Program	*Description*
MaineCare	For individuals who qualify for coverage through a categorical pathway. Services covered include home health, therapies, private duty nursing, personal care, hospice care, adult day health, social worker, psychological services, day habitation, day treatment, community support, and substance abuse treatment.
BME (Elderly) Waiver/ Adults with Disabilities Waiver	For individuals who are 60 or older/18-59 who need nursing care services and choose to remain at home. Some of the services are: care management, adult day services, personal care, home health, some transportation, emergency response system and mental health.
BMR (Bureau of Mental Retardation) Waiver	For individuals of all ages with mental retardation. Assists individuals with independent living arrangements.
Physically Disabled Waiver	For individuals with a physical disability who are 18 or older. Individuals in this program manage and direct their own personal care attendant. Some of the services provided are case management, personal care, and an annual reassessment of needs.
CD PAS Program	For MaineCare members who are physically disabled. Individuals in this program manage and direct their own attendant care services.
Katie Beckett	This is an optional Medicaid coverage group for children who are ineligible for AFDC-related coverage or for coverage as an SSI-related child and who reside in the community, meet the medical need criteria established by Medicaid and meet the SSI criteria for disability.

As the major source of public financing for long-term care services, MaineCare plays a special role for residents with ongoing health needs. Over time, long-term care services have begun to shift from institutions to the community. Several program initiatives aim to help individuals with disabilities remain in the community. Many are operated as waiver programs, which provide the state exemptions from some federal requirements. Programs target different groups, based on type of disability, age, income.

2004 MaineCare Quality Projects & Chronic Disease Prevention/Management Initiatives

MaineCare Medical Homes:

- Provides medical homes for over 160,000 members to assure receipt of appropriate preventive care, lessen the need for episodic care, and keep chronic conditions under control

MaineCare Managed Care Provider Profile and Incentive Payment:

- Managed care primary care providers are tracked for certain quality indicators, receive reports on an individual and peer-comparison basis. Information is fed back to primary care providers quarterly along with a PCP newsletter highlighting clinical information, and an incentive payment is paid to certain primary care providers meeting certain thresholds.

Member Education Referral Cards:

- MaineCare providers may use Member Education Referral Cards to notify MaineCare when they feel a member needs assistance with education about the MaineCare Program or specific health issues.

24-7 Monitoring:

- MaineCare managed care primary care providers are required to provide coverage 24 hours per day, 7 days per week for managed care members.
- Providers monitored on a random basis at least once per year.

Bright Futures Health Assessment Forms:

- To promote Bright Futures standard of care, a more comprehensive visit for well child and adolescent care than other schedules is used; providers receive additional reimbursement and are provided with health assessment forms that act as reminders of what is to be covered.
- MaineCare nurses review each form for needed follow-up. MaineCare member services also assist an eligible member/caretaker to follow recommendations for treatment, including providing assistance with referrals or other needed services.

In providing services to enrollees, MaineCare aims to provide quality care. The program operates several quality initiatives aimed at both enrollees and providers. Many use education as the primary tool, providing information to providers about the quality of care they provide, facilitating member education through referral cards, and directly reaching out to enrollees through mailings, toll-free lines, and other mechanisms. MaineCare also promotes quality care through payment incentives and program requirements for providers.

2004 MaineCare Quality Projects & Chronic Disease Prevention/Management Initiatives

(continued)

Voluntary Pain Management Project:

- Members who receive narcotic prescriptions from multiple providers are invited to join a voluntary pain management program, asked to identify a single physician as their narcotic prescriber, and provided education and assistance other resources.
- MaineCare providers also informed if other providers prescribed narcotics to their patients.

Limiting the Use of ER Services:

- Patients who repeatedly present themselves in the ER for non-urgent needs receive letters reminding them of availability of care in provider's office, are contacted by nurse by telephone to discuss any barriers to receiving care in the PCP's office, and are sent reminder cards on care for non-emergent conditions.
- All MaineCare managed care members receive member education on limiting ER use.
- Primary care providers receive an incentive payment for being available to their patients and keeping patients out of the ER for inappropriate use.

Smoking Cessation:

- Through mailings, members receive education on dangers of smoking and resources to help quitting, with additional mailings targeted to pregnant women. Resources include an 800 line (funded by the Bureau of Health) and coverage for cessation counseling services.

Diabetes:

- Using registry of members with diabetes, provide outreach to providers and patients about required screening services for optimal self-management of the disease.
- Partner with the Maine Primary Care Association to provide aggregate data to FQHCs.

Lead Testing Education and Surveillance:

- Review administrative and claims information to track whether children are receiving lead testing and provide targeted mailings and outreach to families, provider education, and payment incentives for lead testing.

Some quality initiatives are targeted at specific quality issues. For example, MaineCare operates programs to promote appropriate use of narcotics for pain management and efficient use of emergency rooms for care. Smoking cessation, diabetes, and lead exposure reduction initiatives focus on prevention, aiming to promote healthy lifestyles and screening to catch problems early.

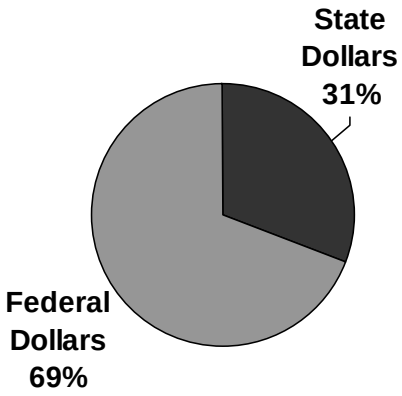
How is MaineCare Financed?

FINANCING

MaineCare is financed through a combination of state funds and federal "matching payments." The level of federal matching payments changes each year, based on the state's per capita income; in recent years, the payment has ranged from 61 to 69 percent of program costs. The federal matching payment is higher for some services (such as family planning and SCHIP). The federal match rate is adjusted each year, reallocating federal Medicaid monies away from states experiencing better economic performance relative to other states, shifting it to those states experiencing relatively poorer performance. This allocation formula does not take into account any population demographics or other special circumstances a state may face.

In state fiscal year 2004, MaineCare expenditures totaled about $2 billion. Over two-thirds of this amount (69%) was funded through federal dollars, with the remaining third paid for with state dollars. In the coming biennium, Maine's federal match rate is expected to decline significantly.

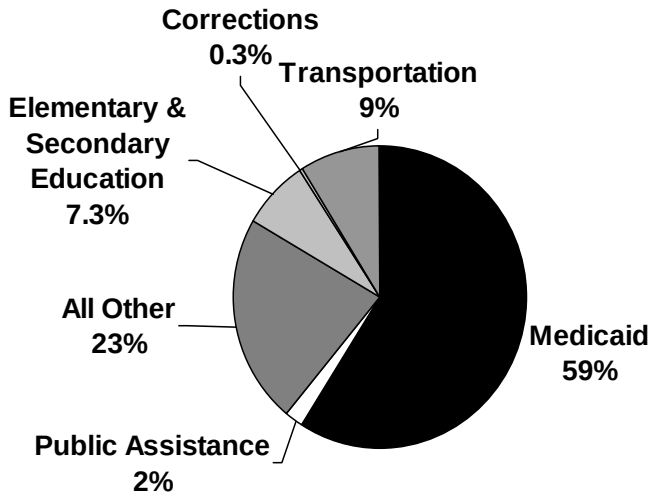
MaineCare Spending by Source of Funds, SFY04



Total = $2 billion

Note: Excludes Title XXI (SCHIP) payments and MaineCare related payments funded with state-only dollars.
SOURCE: Bureau of Medicaid Services administrative data.

MaineCare as a Percent of Federal Grant Expenditures, 2003

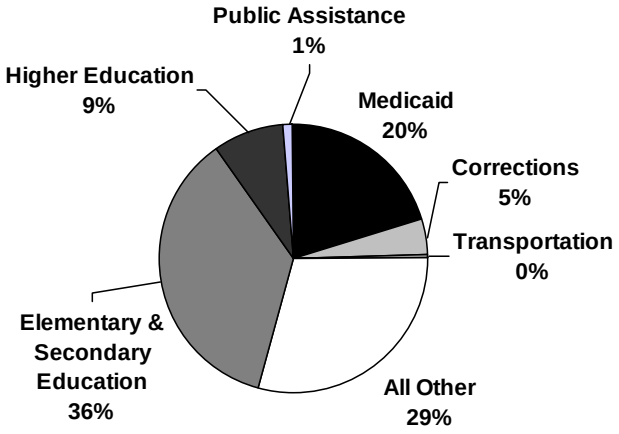


Total Federal Grants = $1.996 billion

SOURCE: National Association of State Budget Officers, 2003 State Expenditure Report, October 2004.

MaineCare brings in more federal money into Maine than any other program. Federal Medicaid matching funds account for 59% of federal grant expenditures to this state. This share is higher than the national figure of Medicaid accounting for 43.5% of federal grants across all states. Transportation and elementary and secondary education are the second and third largest sources of federal assistance, accounting for 9 percent and a little over 7 percent of federal grants, respectively.

State MaineCare Spending as a Percent of General Fund Expenditures, 2003



Total General Fund Expenditures = $2.533 billion

SOURCE: National Association of State Budget Officers, 2003 State Expenditure Report, October 2004.

MaineCare spending accounts for a large share of state general fund expenditures (20%), though it is second to elementary and secondary education (36% of expenditures). This share is slightly higher than the national figure of 16.5% across all states.

WHAT DOES MAINECARE SPENDING LOOK LIKE?

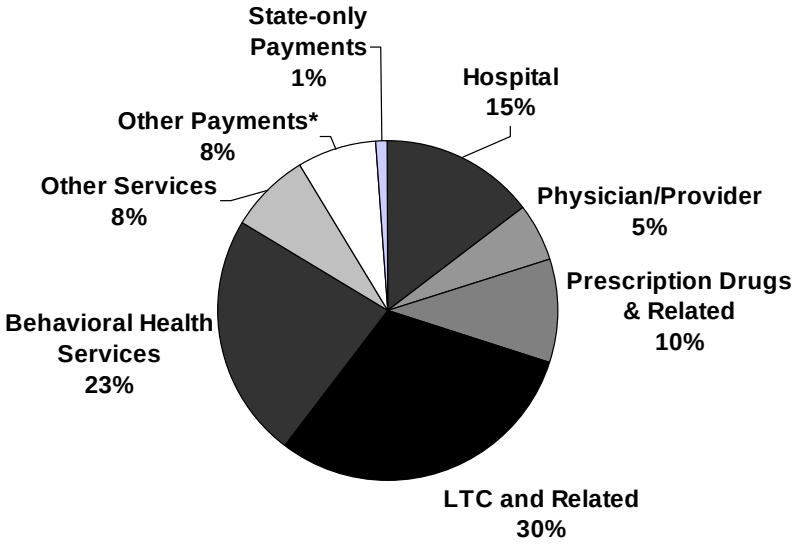
Spending

In state fiscal year 2004 the largest categories of MaineCare spending were long-term and behavioral health services. Long-term care, which includes a range of services from nursing facilities and other institutional care (including Private Non-Medical Institutions) to personal care services and waivers to provide care in the community, accounted for 30 percent of spending. Behavioral health services, spanning from institutional care for persons with mental retardation to day habilitation to home-based mental health care, made up another 23 percent of spending.

Spending on inpatient and outpatient hospital care, including inpatient psychiatric hospitals, comprised 15 percent of spending in, and prescription drugs, lab services, and medical equipment and prosthetics were 10 percent of spending. Payments to providers, which included both physicians and other providers (e.g., clinics, dentists, nurse practitioners, occupational and physical therapists) made up five percent of spending.

The remainder of expenditures was for miscellaneous categories. "Other services" in MaineCare include transportation/ambulance, case management, family planning and sexually-transmitted disease screening, and early intervention/school-based rehab. Other spending includes waiver programs to expand eligibility and payments for Medicare premiums.

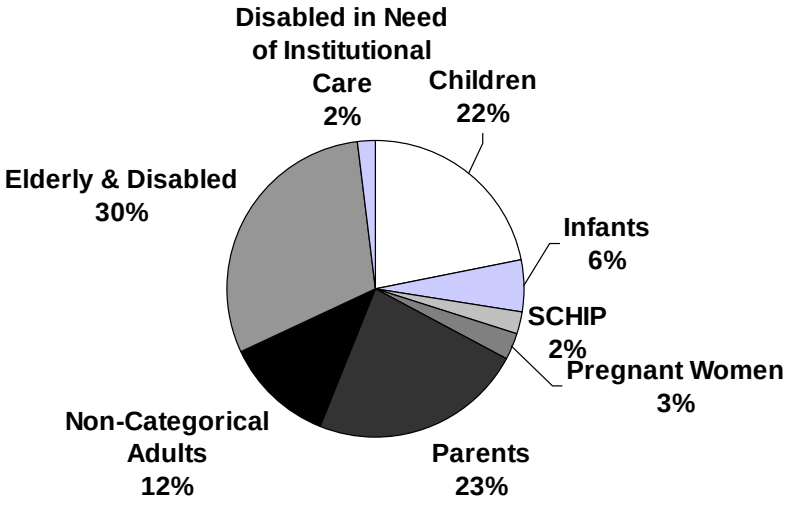
MaineCare Spending by Service Category, SFY04



Total = $2.017 billion

*Includes Medicare Part B premiums, waiver payments, and third-party recoveries.
NOTE: Excludes MaineCare-related state-only payments. Rx includes rebate.
SOURCE: Bureau of Medicaid Services administrative data.

Spending on Acute Care Services by Eligibility Group, SFY2004

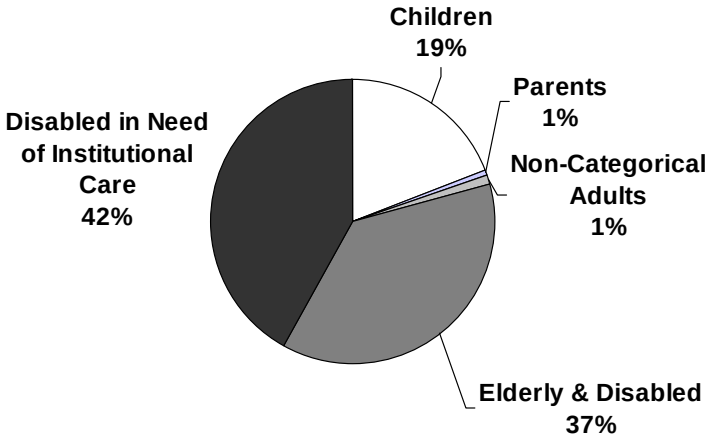


Total = $526,551,895

Note: Working Disabled account for less than 1% of acute care service utilization. Acute care services include: Hospital Inpatient & Outpatient; Mental Health Inpatient & Outpatient; Physician, Podiatrist, Nurse/Midwife, LCSW/LCPC, and Family and Pediatric Nurse Practitioner Services; PHP Agency, Federally Qualified Health Center, Independent Lab, Ambulatory Surgical Center, Ambulatory Care Clinic Service, & Certified Rural Health Clinic; Speech/Hearing; Physical & Occupational Therapy, Chiropractic, Optometric & Optical, Audiology, Speech Pathology, and Dental Services.
SOURCE: Bureau of Medicaid Services administrative data.

Examination of spending by eligibility group shows that acute care service spending is split fairly evenly across children, adults, and elderly and disabled enrollees. Children account for 30% of acute care spending, and non-disabled adults account for 38% of acute care spending. Elderly and disabled enrollees account for the last third of spending for acute care services (32%).

Spending on Long-Term Care and Related Services by Eligibility Group, SFY2004

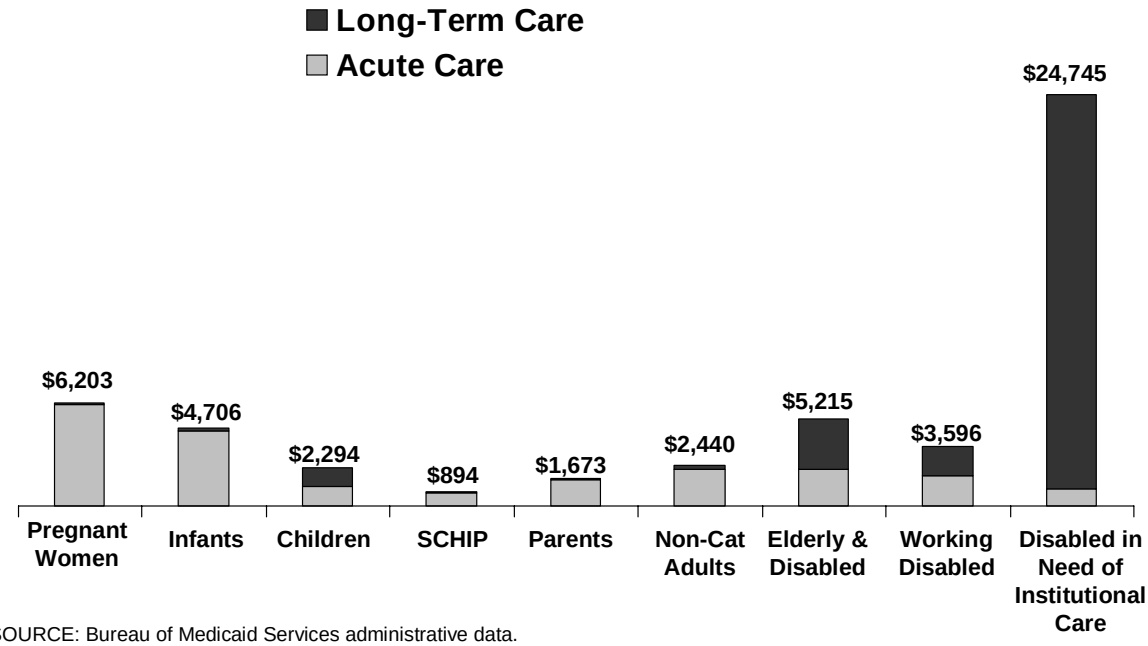


Total = $574,731,972

Note: SCHIP, Infants, Pregnants Women, and Working Disabled account for less than 0.5% of long-term care service utilization. Long-term care and related services include: Nursing Facility, Home Health, Hospice, Day Health, Private Duty Nursing, Personal Care Services, Rehab. Services (Head Injury), Swing Bed, Private Non-Medical Institutions, Medicare Crossover, and long-term care waiver services.
SOURCE: Bureau of Medicaid Services administrative data.

In contrast to acute care services, the majority of long-term care spending is for services used by elderly and disabled MaineCare enrollees. Children, parents, and adults account for just one-fifth (21%) of long-term care spending, while the elderly and disabled account for 37%. The disabled in need of institutional care account for the largest share of long-term care spending, with 42% of spending going toward this group.

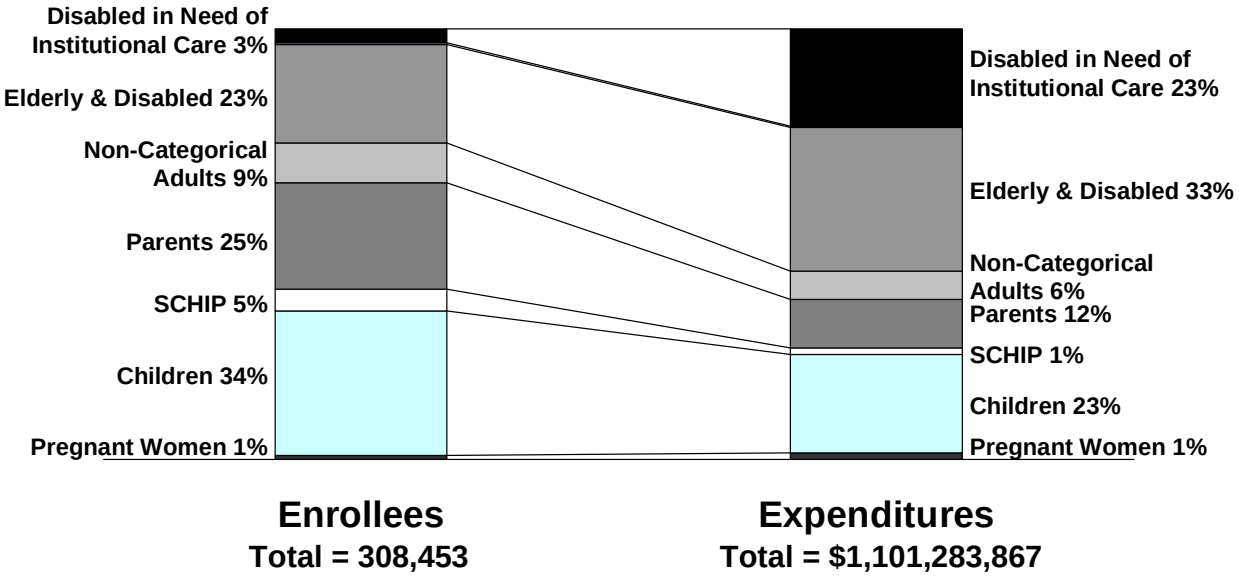
MaineCare Expenditures Per Enrollee by Acute and Long-Term Care, SFY04



SOURCE: Bureau of Medicaid Services administrative data.

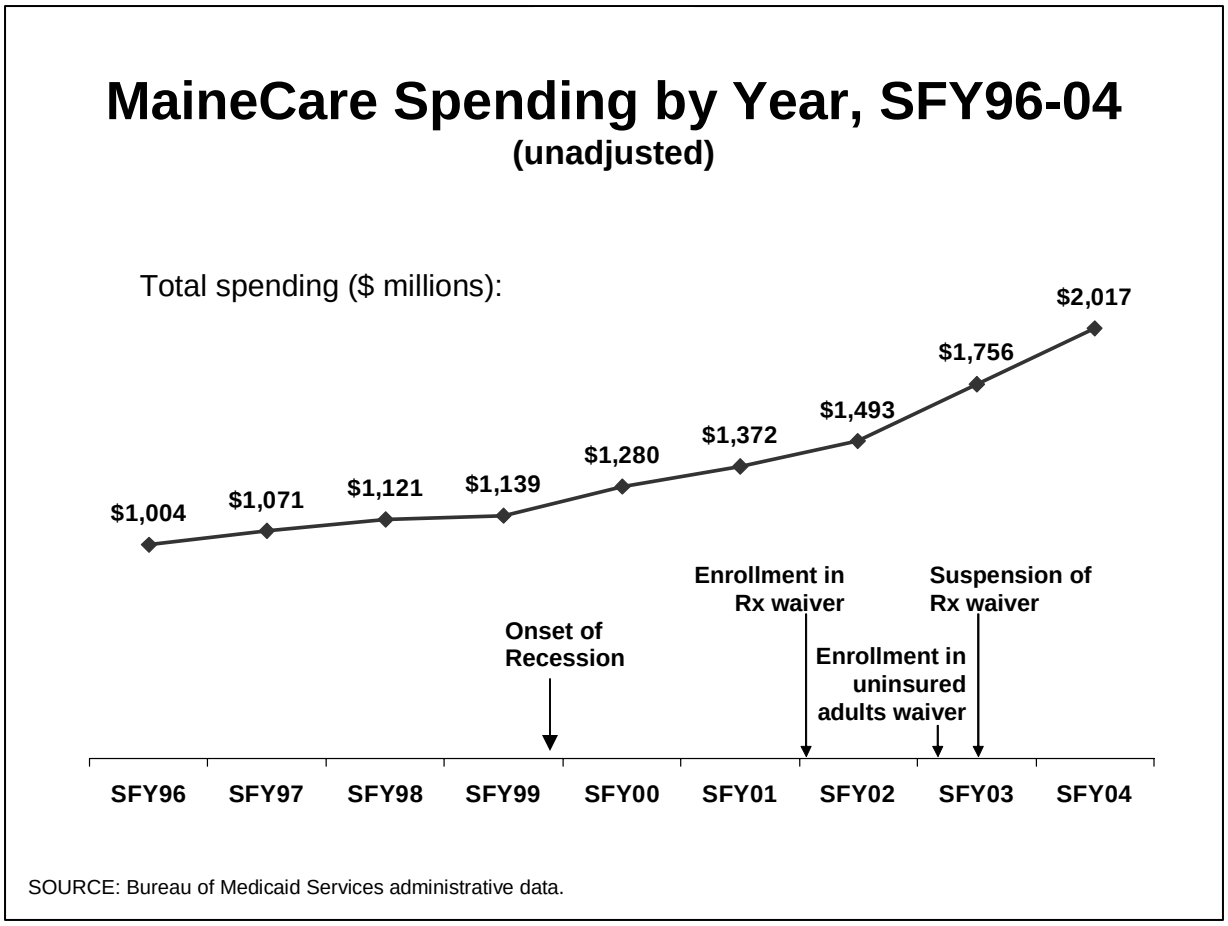
Spending per enrollee in MaineCare varies by eligibility group. Children, parents, and non-categorical adults have the lowest rate of spending, with per capita costs of $894, $1,683, and $2,440, respectively. Infants and pregnant women have higher per capita costs, largely driven by spending on acute care services. Elderly and disabled individuals' spending is driven by both acute care and long-term care spending. Enrollees who qualify as disabled in need of institutional care have by far the highest rate of spending, costing an average of $24,745 per year. As the figure shows, most of this spending is driven by long-term care services that this group requires.

MaineCare Enrollees and Expenditures by Enrollment Group, SFY04



NOTE: Children also includes infants; working disabled (not included in figure) account for .25 percentage point for both enrollment and expenditures.
SOURCE: Bureau of Medicaid Services administrative data.

Differences in per capita spending means that a minority of enrollees makes up a majority of spending. Though the elderly, disabled, and disabled in need of institutional care comprise just over a quarter (26%) of enrollees, they account for 62 percent of expenditures. This difference is due to the high cost of services that these groups require, such as long-term care and prescription drugs.



MaineCare expenditure data (unadjusted for inflation) shows that the program's total spending has increased as the cost of medical care has increased, as it has served more enrollees, and as the service mix has shifted to more costly services. If these figures were adjusted for inflation the actual expenditure figures would be lower.

Average Annual Growth Rates in MaineCare Spending by Service Category, SFY96-04

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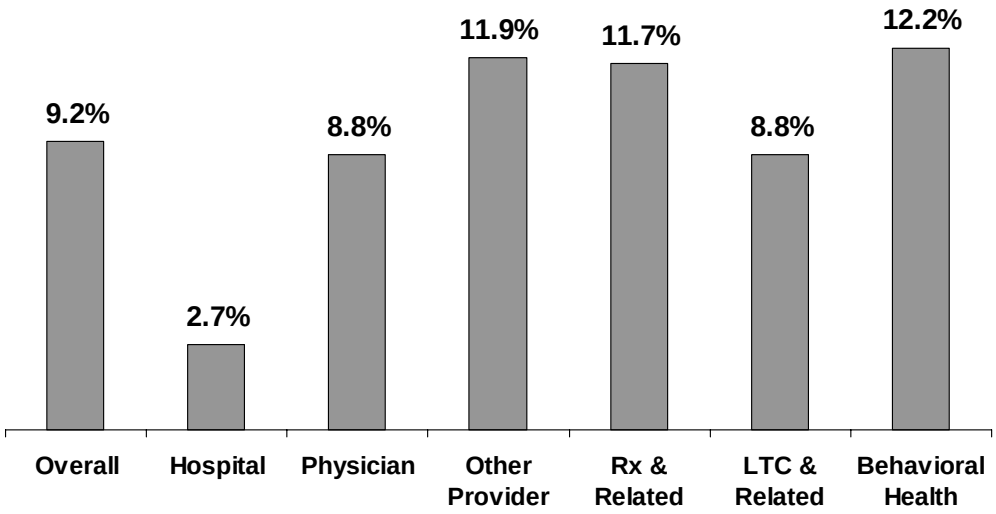
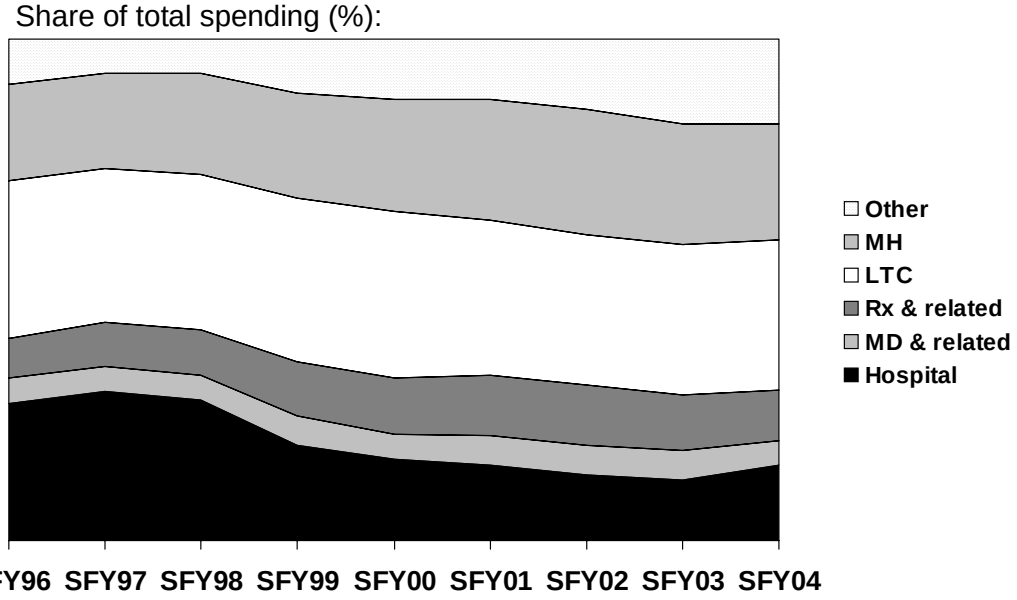


SOURCE: Bureau of Medicaid Services administrative data.

Over the past eight years, MaineCare spending growth has been larger in some areas than others. Hospital costs increased on average 3 percent a year, while other providers (non-physician providers such as chiropractors, therapists, home health providers, etc.), prescription drug and related items, and behavioral health each increased at about 12 percent. Average annual growth rates for physician and long-term care were similar to that for the program overall– about 9 percent.

Composition of MaineCare Spending by Year, SFY96-04

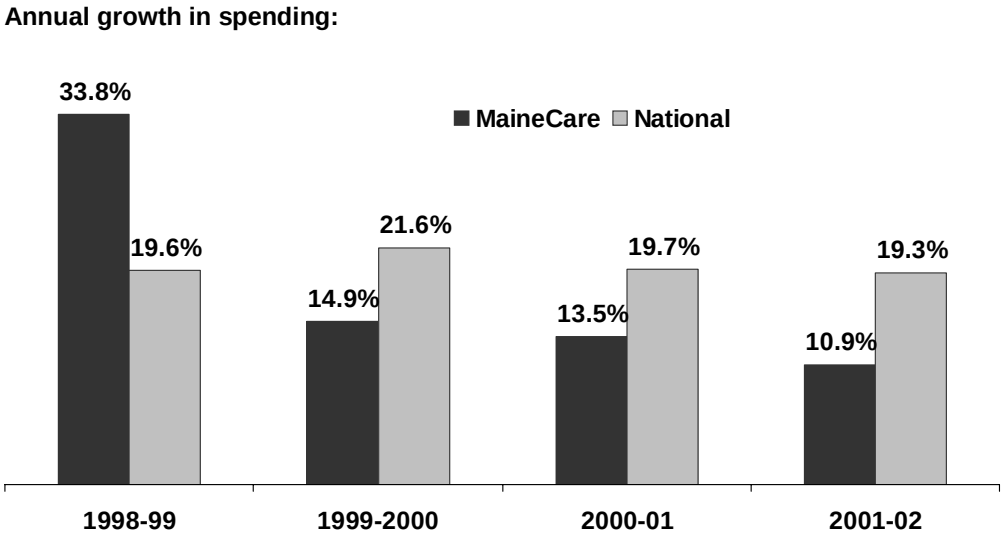
(unadjusted)



SOURCE: Bureau of Medicaid Services administrative data.

Differences in spending growth have changed the composition of MaineCare spending over time. In the late 1990s, hospital spending accounted for a larger share of expenditures than it has in the past several years, moving from a high of 30 percent of spending in 1997 to a low of 12 percent in 2003. "Other" spending has increased as a share of program costs as initiatives were implemented, and behavioral health and related services have increased from about one-fifth to about one-fourth of MaineCare expenditures. Prescription drugs, though a smaller share of total spending, shifted from 8 percent of spending to a high of 12 percent, then dipped down to 10 percent. Physician and provider costs have remained stable as a share of spending, holding at five to six percent of program spending. Similarly, long-term care services consistently account for 30-33 percent of spending.

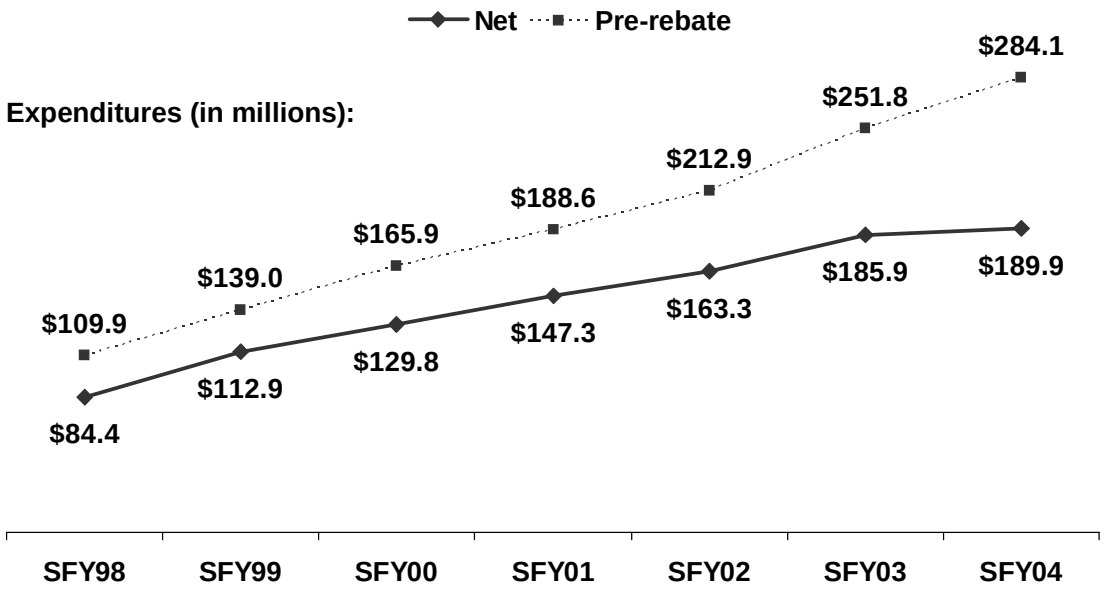
MaineCare and National Growth Rates in Prescription Drug Spending, 1998-2002



NOTE: MaineCare data is for state fiscal year; national data is for calendar year.
SOURCE: Bureau of Medicaid Services administrative data; Bruen and Ghosh, June 2004.

Like many states' Medicaid programs, MaineCare has been faced with increasing prescription drug costs. Medicaid prescription drug costs are driven by the number of prescriptions filled by enrollees or number of enrollees using prescription drugs, and the price of drugs or types of prescriptions that are used. MaineCare has initiated efforts to slow cost increases, such as prior authorization and use of a preferred drug list, which have decreased the growth rate in prescription drug spending in recent years. While the number of prescription drug users and number of prescriptions filled has continued to increase, post-rebate costs per user have begun to decline, from a high of $944 in 2002 to $862 in 2004.

MaineCare Outpatient Prescription Drug Spending Over Time



SOURCE: Bureau of Medicaid Services administrative data.

Compared to national data, MaineCare's rate of increase in prescription drug spending has slowed. From 1998 to 1999, MaineCare's drug costs increased at a faster rate than national costs; however, beginning in 2000, prescription drug costs increased at a slower rate than national costs.

MaineCare Expenditures for Service Users, SFY 2002

Age group	Service users with Mental Retardation/Developmental Disabilities				
	Average monthly expenditures	Behavioral services[1]	Long term care	Medical/ other services	All services
0-64	$4,421	80.2%	3.1%	16.7%	100.0%
65+	$4,579	65.9%	19.9%	14.1%	100.0%
All ages	$4,435	78.9%	4.7%	16.4%	100.0%

Age group	Service users with Mental Health/Substance Abuse Condition				
	Average monthly expenditures	Behavioral services	Long term care	Medical/ other services	All services
0-64	$830	43.3%	5.8%	50.9%	100.0%
65+	$1,933	15.1%	68.0%	17.0%	100.0%
All ages	$950	37.0%	19.6%	43.4%	100.0%

Age group	Services users with both MR/DD and MH/SA				
	Average monthly expenditures	Behavioral services	Long term care	Medical/ other services	All services
0-64	$1,087	54.1%	5.0%	41.0%	100.0%
65+	$2,087	21.6%	61.8%	16.6%	100.0%
All ages	$1,195	47.9%	15.7%	36.4%	100.0%

Age group	Other service users *without* behavioral conditions				
	Average monthly expenditures	Behavioral services[2]	Long term care	Medical/ other services	All services
0-64	$191	1.9%	12.8%	85.3%	100.0%
65+	$774	2.4%	65.3%	32.3%	100.0%
All ages	$272	2.1%	33.5%	64.4%	100.0%

Data prepared by S. Payne, et al. Muskie School of Public Service

In 2002, more than 40 percent of all MaineCare members who used one or more covered services had a behavioral health condition. These members accounted for approximately 76 percent of MaineCare expenditures. Behavioral health conditions include depression, schizophrenia, anxiety, cognitive disorders, substance abuse and alcohol related mental disorders, mental retardation and developmental disabilities.

In SFY 2002, MaineCare spent $1.2 billion for medical and behavioral health services for MaineCare members with behavioral health conditions. Of this total, behavioral health services alone accounted for $567 million. Behavioral health services include a range of residential, community based counseling and support, mental retardation waiver program, substance abuse, developmental and pharmacy (psychotropic medication) services. The remaining expenditures were for “routine” services such as hospital and physician care, transportation, medical supplies, etc. The chart above shows the average monthly expenditures for different groupings of members, broken down by general service types.

Numbers and Spending for Service Users With and Without Behavioral Health Conditions, 1996-2002

	State fiscal year				Percent change
	1996		2002		
Population	**Number**	**Percent**	**Number**	**Percent**	
Service users with MR/DD	*3,418*	*2.1%*	*5,796*	*2.7%*	*69.6%*
Service users with MH/SA	*46,183*	*28.5%*	*81,377*	*38.3%*	*76.2%*
Sub-total: MR/DD & MH/SA	49,601	30.6%	87,173	41.0%	75.7%
Other service users	112,602	69.4%	125,227	59.0%	11.2%
All MaineCare service users	**162,203**	**100.0%**	**212,400**	**100.0%**	**30.9%**
Total expenditures					
Service users with MR/DD	*$137,396,090*	*17.0%*	*$304,063,150*	*19.9%*	*121.3%*
Service users with MH/SA	*$396,841,771*	*49.0%*	*$863,179,681*	*56.6%*	*117.5%*
Sub-total: MR/DD & MH/SA	$534,237,860	65.9%	$1,167,242,831	76.5%	118.5%
Other service users	$276,076,076	34.1%	$357,591,540	23.5%	29.5%
All MaineCare service users	**$810,313,936**	**100.0%**	**$1,524,834,371**	**100.0%**	**88.2%**
Per service user per month expenditures					
Service users with MR/DD		*$3,447*		*$4,435*	*28.7%*
Service users with MH/SA		*$812*		*$950*	*17.1%*
Sub-total: MR/DD & MH/SA		$1,010		$1,195	18.3%
Other service users		$249		$272	9.1%
All MaineCare service users		**$495**		**$665**	**34.4%**

Data prepared by Susan Payne, et al., Muskie School of Public Service.

"Service users" are MaineCare members who use one or more covered services in a given period of time; not all members use covered services.

In 2002, MaineCare spent more per month on members who have a behavioral health condition ($1,195) than on members without such conditions ($272). Between 1996 and 2002, per person spending for members with behavioral health conditions increased more rapidly than it did for members without such conditions (18.3% v. 9.1%). Spending for persons with mental retardation/developmental disabilities grew at a faster pace than did spending for members with a mental health/substance abuse disorder. Overall spending for members with behavioral health conditions is driven by a combination of factors: the numbers of persons eligible for and using covered services as well as the cost and mix of services used by these members.

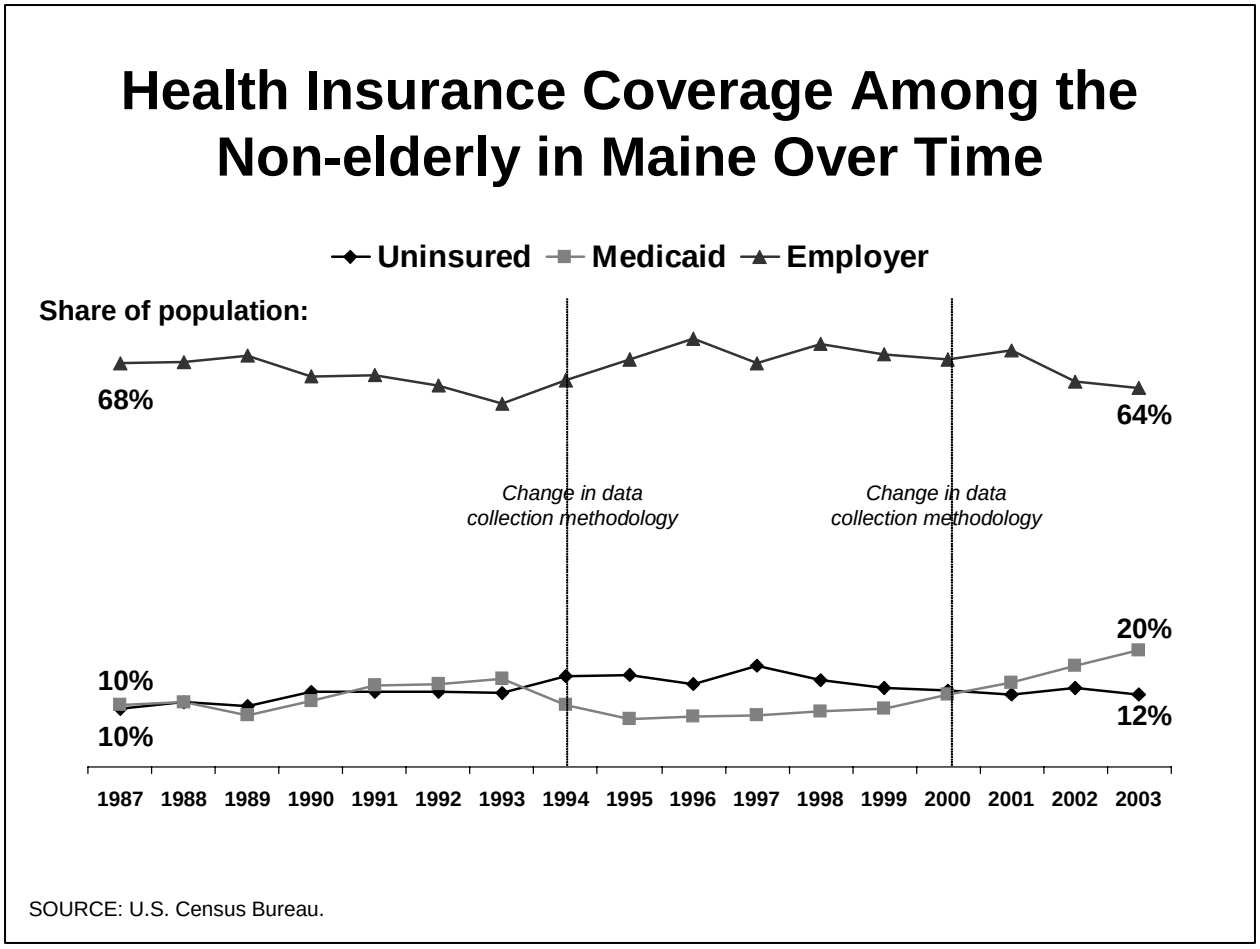
Between 1996 and 2002 there was a substantial increase in the proportion of MaineCare service users with a behavioral health condition. This phenomenon contributes to the overall increase in the average overall cost per service user for MaineCare, generally.

WHAT IS MAINECARE'S LARGER IMPACT?

MAINECARE'S IMPACT

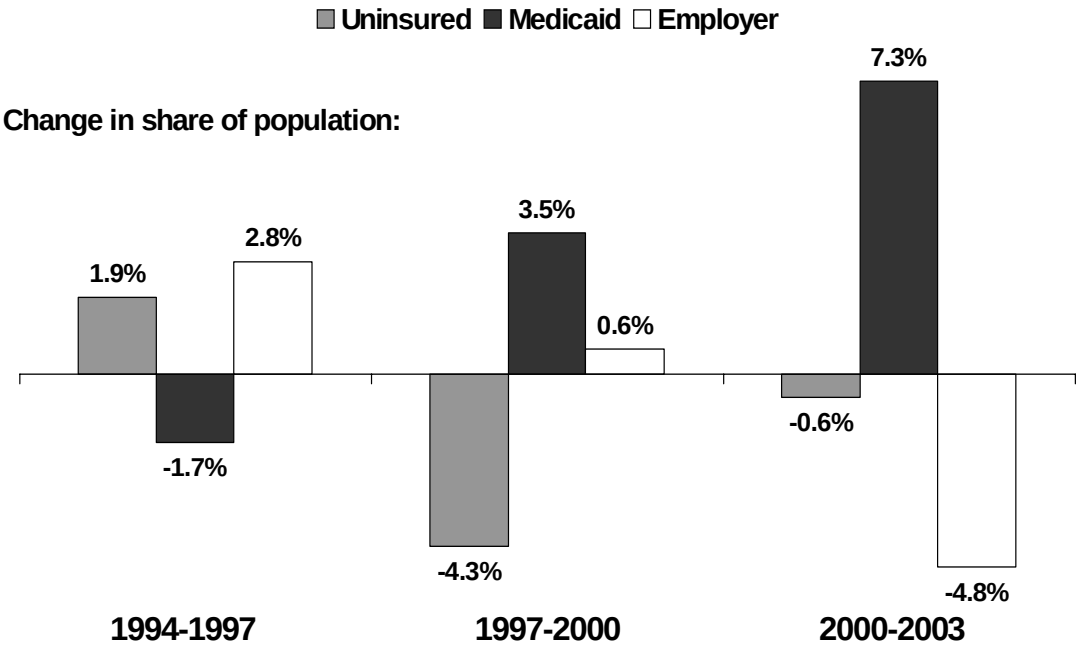
MaineCare has an impact on health insurance coverage in the state. Though a majority of the population is covered through employer-sponsored health insurance, many do not receive coverage through their or their families' jobs. MaineCare fills in some of this gap, covering many who would otherwise be uninsured.

After reaching a high of 72% in 1996, the share of the population with employer-based coverage dropped, and the share of uninsured rose. MaineCare slowly expanded to fill in this gap, reducing the share of the state's residents without any coverage from 17% in 1997 to 12% in 2003.



SOURCE: U.S. Census Bureau.

Changes in Health Insurance Coverage Among the Non-elderly in Maine



SOURCE: Analysis of Current Population Survey, U.S. Census Bureau.

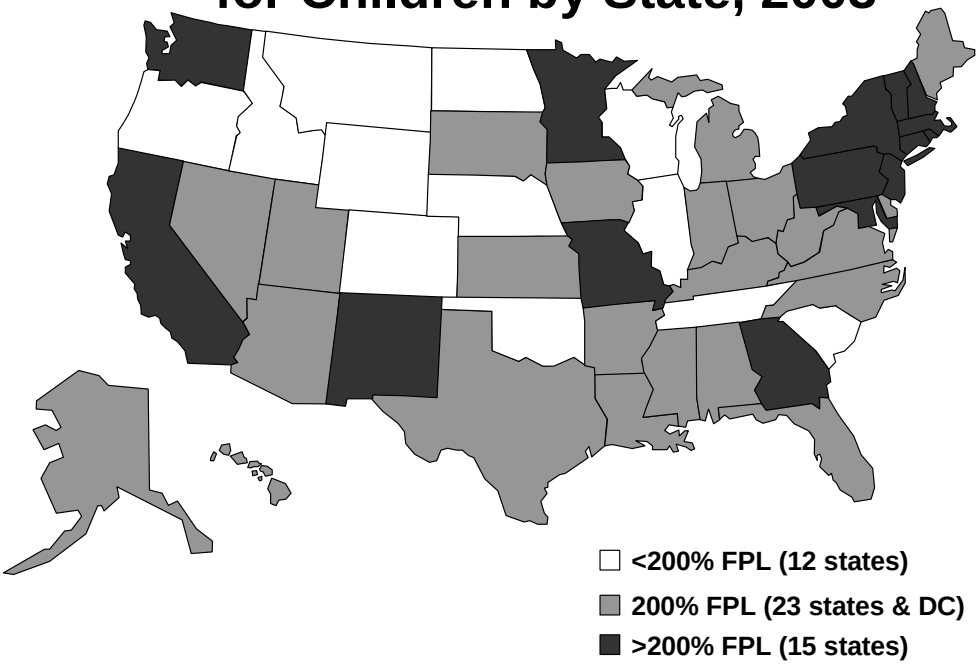
MaineCare does not "crowd out" private coverage. When MaineCare coverage was declining in the late 1990s, the number of uninsured was increasing, even though employer-based coverage was covering more residents. When MaineCare coverage increased in the late 1990s in conjunction with an increase in employer-based coverage, the share of the population without any coverage fell. As employer coverage fell in the last few years with the downturn in the economy, MaineCare expanded to fill in some of the gap, leading to only a small change in the share of the population uninsured.

How Does MaineCare Compare With Medicaid Programs in Other States?

MaineCare Compared to Other States' Medicaid Programs

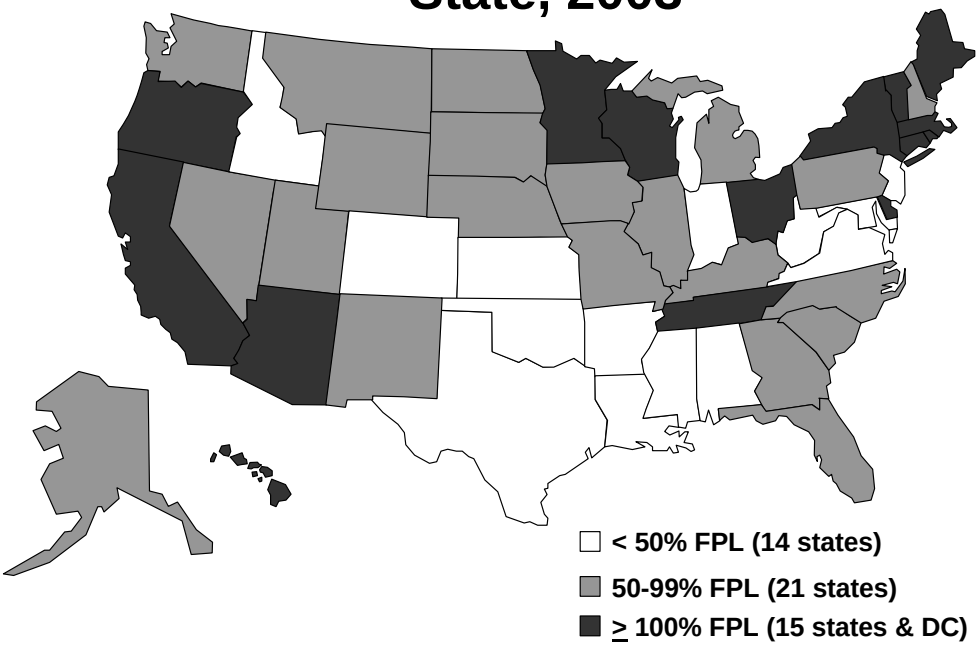
Compared to other states, MaineCare's eligibility levels for children are at the median. The state joins 22 other states and the District of Columbia in covering children up to twice the poverty level. Fifteen states cover children whose family income is above that level, and 12 states limit coverage to children in families with incomes below twice the poverty level.

Medicaid/SCHIP Income Eligibility Levels for Children by State, 2003



SOURCE: Ross & Cox, July 2003.
Note: MA and PA cover children over 200% FPL with state-only dollars.

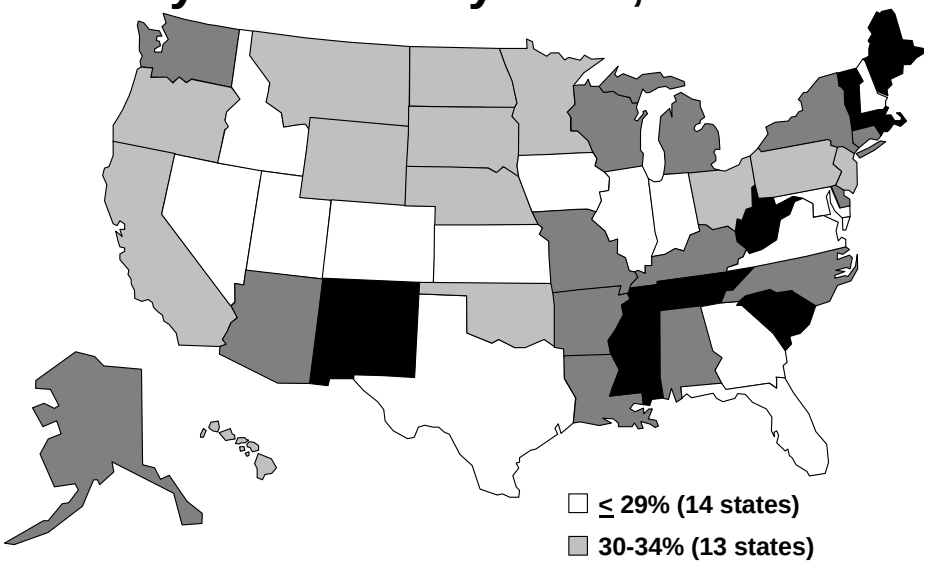
Medicaid Eligibility Levels for Parents by State, 2003



SOURCE: Ross & Cox, July 2003.
Note: Indicates levels for working parents. For non-working parents, FL, GA, IL, IA, KY, MI, MT, NE, NV, NH, NM, NC, ND, PA, SC, UT, WA and WY all move down one category. PA and WA have closed enrollment in state-funded programs that cover parents at higher income thresholds. UT providesprimary care services to parents with income up to 150% of poverty.

For parents, MaineCare covers individuals at levels above the national median. Like 14 other states and the District of Columbia, Maine extends coverage to parents up to 150% of the poverty level. In contrast, 14 states cover parents up to just half the poverty level, and 21 states cover parents up to the poverty level.

Share of Low-Income Population Covered by Medicaid by State, 2002-2003

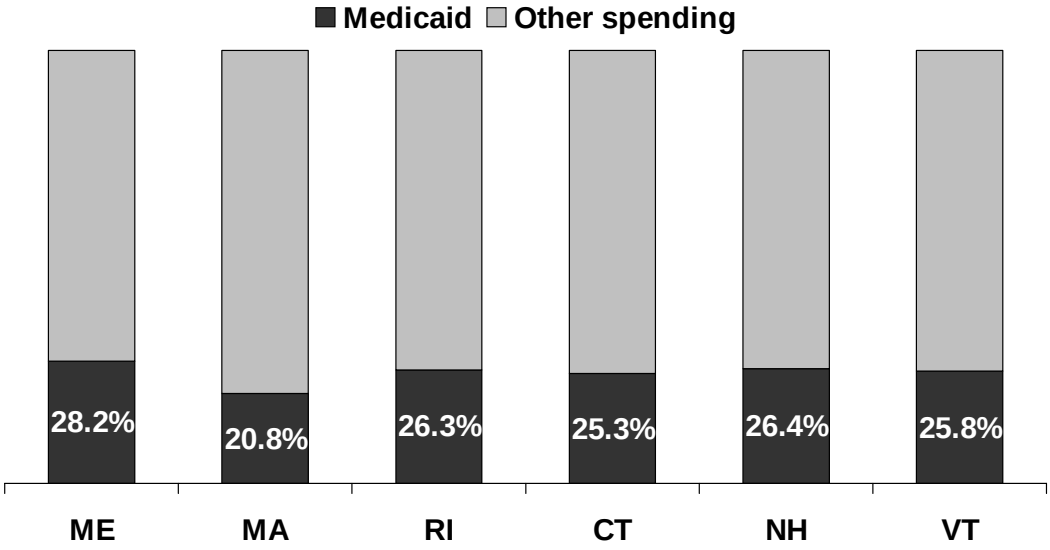


SOURCE: State Health Facts Online.
NOTE**:** Persons in poverty are defined as those who make less than 100% of the Federal Poverty Level (FPL), referred to as the poverty threshold. The federal poverty threshold for a family of three was $14,348 in 2002 and $14,680 in 2003.

Compared to other states and the national average, MaineCare covers a larger share of the state's poor population (residents below the poverty level). Over half of this population targeted by Medicaid is enrolled in the program in Maine, as is the case in seven other states and the District of Columbia.

Similarly, MaineCare extends coverage to a greater share of low-income (people living below twice the poverty line) residents than most other states. Like 8 other states and the District of Columbia, Maine covers over 40 percent of the state's low-income residents.

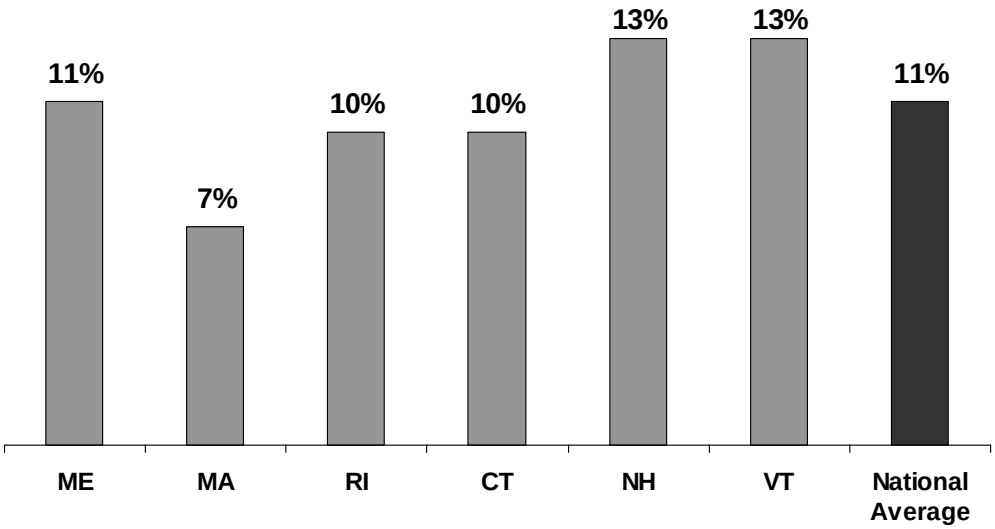
Medicaid Expenditures as a Share of Total Expenditures Among New England States, 2003



NOTE: Includes provider taxes, fees, donations, assessments, and local funds.
SOURCE: National Association of State Budget Officers, 2003 State Expenditure Report, October 2004.

Compared to other New England states, Maine spends a slightly higher share of total state expenditures on Medicaid. Medicaid accounts for just over 28 percent of spending in Maine, and just over 26 percent in Rhode Island and New Hampshire. Both Connecticut and Vermont spend a little over a quarter of state spending on Medicaid, and Massachusetts spending a little over a fifth.

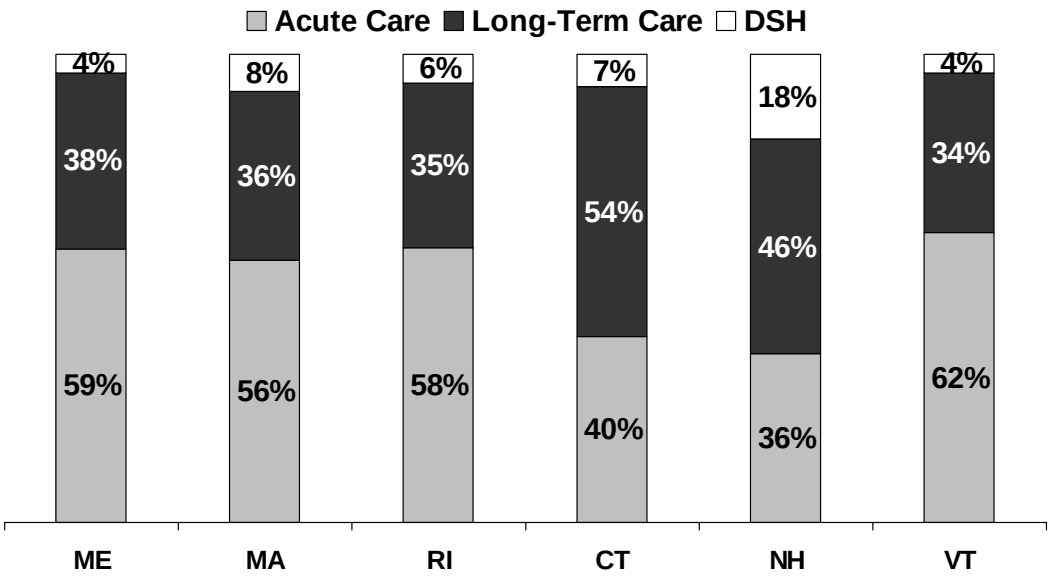
Average Annual Growth in Total Medicaid Spending Among New England States, 1991-2001



SOURCE: State Health Facts Online.

Maine's average annual growth rate in Medicaid spending is in the middle of the range for New England states. New Hampshire and Vermont both had annual cost increases of 13 percent form 1991 to 2001, while Rhode Island and Connecticut had average annual cost increases of 10%. Massachusetts had an annual cost increase of 7 percent. Maine's average annual increase of 11 percent was equal to the national average for all 50 states. (Note: more current data are unavailable.)

Distribution of Medicaid Spending By Service Category Among New England States, 2000



NOTE: Numbers may not total to 100% due to rounding.
SOURCE: State Health Facts Online.

As compared to other New England states, Maine's distribution of spending is in the middle of the range. Versus Connecticut and New Hampshire, which spend more on long-term care than acute care, Maine, Massachusetts, Rhode Island, and Vermont all spend more on acute care services than long-term care. Maine also has a smaller share of spending from Disproportionate Share Hospital (DSH) payments than any New England state except Vermont (which has an equal share).

HOW IS MAINECARE ADMINISTERED?

Administration

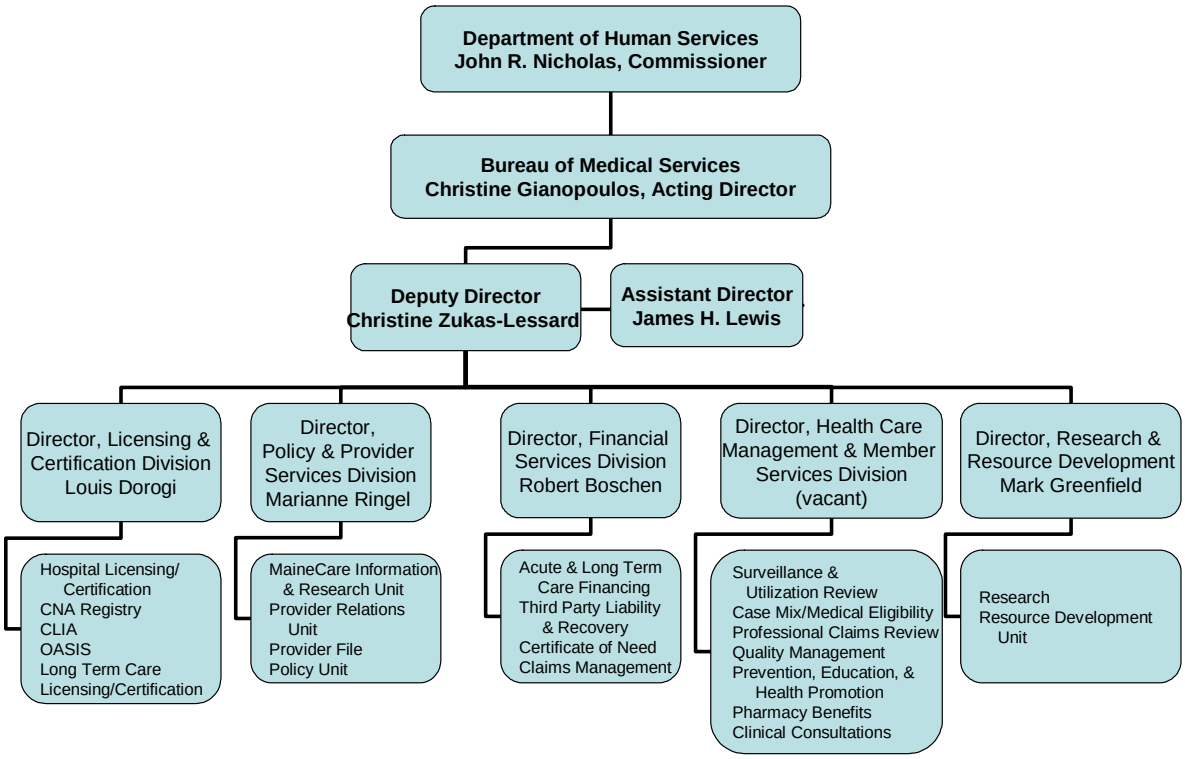
MaineCare is administered by the Bureau of Medical Services (BMS) within the Department of Health and Human Services under the leadership of Commissioner Jack Nicholas. The Governor's Office of Health Policy and Finance coordinates policy and health reform across all Departments, including Health and Human Services.

Five divisions within BMS oversee different aspects of the program. Employees working in MaineCare operations undertake a variety of tasks, such as (but not limited to):

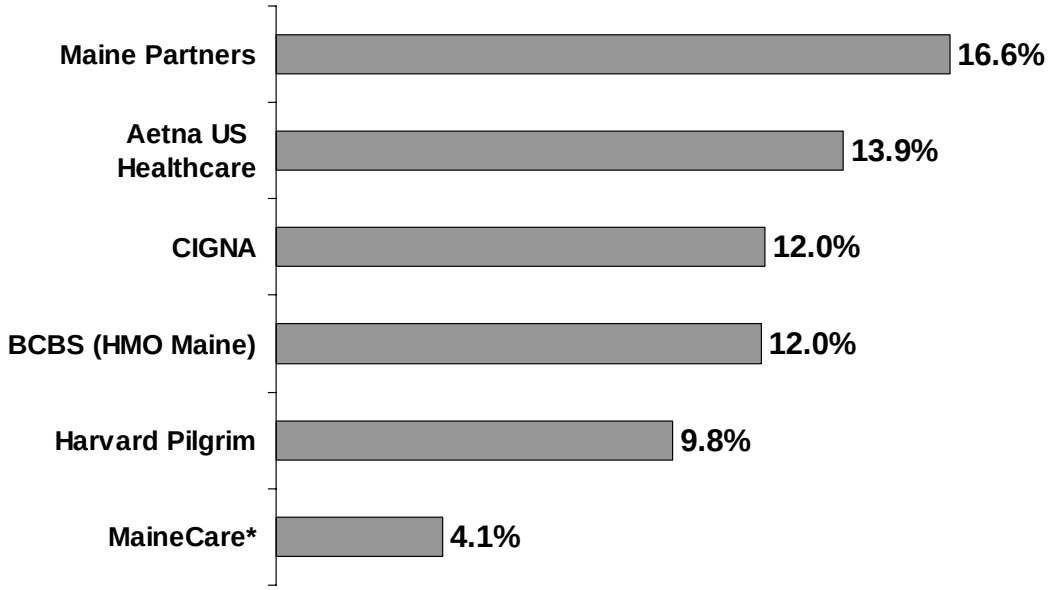
- responding to requests for information from enrollees and providers
- developing rules and procedures
- processing and reviewing claims
- monitoring compliance
- training providers
- addressing complaints

A MaineCare Advisory Committee, made up of individuals from consumer and provider organizations, advises the agency about health and medical services.

MaineCare Administration, June 2004



Administrative Costs as a Share of Spending by Payer, 2004



* MaineCare figure is for SFY2004.

SOURCE: Bureau of Insurance data.

Compared to other payers in the state, MaineCare spends a much lower share of expenditures on administrative costs. MaineCare spent just over 4 percent of spending on administration, versus about 10% and up for major private payers' plans in the state.

APPENDIX